

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution-General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 09-14-04.

The IRO reviewed office visits, therapeutic procedures, therapeutic activities, data analysis and manipulations rendered from 06-06-03 through 01-21-04 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 01-27-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

Review of CPT codes 97530, 97110, 99213-25, 98941 and 99213 dates of service 10-17-03, 10-20-03 and 10-22-03 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement recommended.

This Findings and Decision is hereby issued this 1st day of March 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

November 17, 2004

Amended Letter 02/04/05

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-05-0194-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 39 year-old male injured his back on ____ while moving a heavy chain. He has been treated with medications, therapy, epidural injections and surgery.

Requested Service(s)

Office visits, therapeutic procedures, therapeutic activities, and manipulations for dates of service 06/06/03 through 01/21/04 and computer data analysis for date of service 04/13/03

Decision

It is determined that there is no medical necessity for the office visits, therapeutic procedures, therapeutic activities, and manipulations for dates of service 06/06/03 through 01/21/04 and the computer data analysis for date of service 04/13/03 to treat this patient's medical condition.

Rationale/Basis for Decision

Physical medicine is an accepted part of a rehabilitation program following an injury. However, for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. In this case, medical record documentation does not indicate an objective or functional improvement in this patient's condition nor evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment. The medical information did not include any records that documented that the disputed treatment was actually performed, nor were there any re-examinations indicating that progress was occurring.

The Guidelines of Chiropractic Quality Assurance and Practice Parameters¹ Chapter 8 under "Failure to meet Treatment/Care objective" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." In this case, the 4-week maximum for non-responsive treatment ended several years before the disputed treatment in question.

¹ Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractor Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.

The patient's handwritten notes on 01/02/03 and on 01/19/04 indicate that the patient's pain ratings remained unchanged and the subjective narrative reported very sharp pain in his low back, stiffness and tingling in both legs...thus indicating that no improvement had occurred.

Without demonstration of objective progress, ongoing treatment cannot be reasonably expected to restore this patient's function and thus is deemed medically unnecessary. Therefore, office visits, therapeutic procedures, therapeutic activities, and manipulations for dates of service 06/06/03 through 01/21/04 and the computer data analysis for date of service 04/13/03 were not medically necessary for the treatment of the patient's medical condition.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm
Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-0194-01

Information Submitted by Requestor:

- Progress Notes – 2000 through 2004
- Daily Treatment Records 2003 through 2004
- Maximum Impairment Rating 1997 through 1999
- Diagnostic Tests 1997 through 1999
- Operative Reports 1998 through 2002
- Pain Management Records 1996 through 2001
- Work Hardening Program 1997
- Functional Capacity Evaluation 1997
- Disputes, Legal Procedures and Claims
- Daily Treatment Records 1997 through 2002
- Duplicate Records

Information Submitted by Respondent: